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24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

c. Care and services provided in Christian Science sanitoria.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

e. Emergency hospital services.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

*Description provided on attachment.

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25. Home and Community Care for Functionally disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____provided ___X___not provided

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

___X___provided _____not provided

Limitation on the funding of abortions -- Applicable to Inpatient Hospital Services (Item 1. on page 1 of Attachment 3.1-A); Outpatient Hospital Services (Item 2.a. on page 1 of Attachment 3.1-A); Physician's Services (Item 5.a. on page 2 of Attachment 3.1-A); and Clinic Services (Item 9. on page 4 of Attachment 3.1-A).

Effective for dates of service beginning October 1, 1993 no public funds shall be expended for any abortions except when it is made known to the Department of Social Services, Division of Medical Services that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape as defined in Chapter 566, Revised Statutes of Missouri or incest, as defined in Chapter 568, Revised Statutes of Missouri.

Coverage of an abortion to save the life of the mother requires the performing physician to certify in writing to the Division of Medical Services that, on the basis of his or her professional medical judgement, the mother's life would be endangered if the fetus were carried to term. This information is reviewed by a Division of Medical Service Medical Consultant who must agree to the medical finding of necessity. Such certification must include the name, address, and medical assistance number of the patient.

Coverage of an abortion to end a pregnancy that is the result of rape or incest requires the performing physician to certify in writing to the Division of Medical Services that the pregnancy is the result of an act of rape or incest. Such certification must include the name, address, and medical assistance number of the patient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Missouri

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Description of Limitation

All services described below, except family planning procedures must be medically necessary in order to be reimbursable through the Missouri Medicaid Program. The specific program limitations may be found in much greater detail in the provider manuals as sponsored by the Missouri Department of Social Services.

For medically necessary services which are included as covered under provisions of this state plan or by reference, except for inpatient hospital services for which exceptions are herein provided separately, the state will consider extensions of limits to the amount, duration and scope, or the additions of specific services on an individual case-by-case basis. The requisites of recipient eligibility, provider program participation and state coverage of the type of medical service represented must be met. According to the circumstances of the individual case, the state agency, through a formal process of consideration, may approve such exception services on a retrospective or prior authorized basis. Applied uniformly as applicable, basic criteria of consideration will include, but not be limited to, relative probable effects on the health and medical condition of the recipient resulting from approval or denial of the exception, cost and cost effectiveness of exception approval considered from perspective of possible alternative services and related costs and health benefits.

Reimbursement for such exception services may be made on a retrospective or a prior authorized basis. Program reimbursement for services excepted through this process shall be in accordance with established fee schedules or rates for same or comparable services or such fee or rate for the total service or components determined by the state as reasonable with relation to charges.

1. Inpatient Hospital Services

The number of days which Medicaid will cover shall be limited to the lower of--

(A) The number of days indicated as appropriate in accordance with whichever of the following length-of-stay schedules is applicable to the individual case:

(1) For the diagnosis at the 75th percentile average length-of-stay in the 1988 edition of the Length of Stay by Diagnosis and Operation, North Central Region;

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(2) An average length-of-stay schedule, as developed by the Medicaid agency, for limited categories of rehabilitation services provided in specific facilities;

(3) An average length-of-stay schedule, as developed by the Medicaid agency, for liveborn infants according to type of birth.

(4) For infants who are less than one (1) year of age at admission, all medically necessary days will be paid at any hospital. For children who are less than six (6) years of age at admission and who receive services from a disproportionate share hospital, all medically necessary days will be paid.

(5) Continued stay reviews will be performed for alcohol and drug abuse detoxification services to determine the days that are medically necessary and appropriate for inpatient hospital care.

;or

(B) The number of days certified as medically necessary by the Hospital Utilization Review Committee, or;

(C) The number of days billed as covered service by the provider.

In administering this limitation, counting of the days which may be allowable shall be from the beginning date of an admission which has been certified, or exempted from certification, and for a continuous period of hospitalization or if later, the beginning date of recipient Medicaid eligibility or the first day of Title XIX coverage following exhaustion of Title XVIII Part A benefits.

Certification of inpatient hospital admissions occurring on and after November 1, 1989 shall be conducted in accordance with the provisions of state rule 13 CSR 70-15.020. The medical review agent for the state applies criteria for medical necessity and appropriateness of the admission. Denial of certification of admissions subject to review will result in program non-coverage of inpatient services if provided, or recovery if review is retrospective to provision of service and admission certification is denied.

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Coverage of services related to the performance of certain specified elective surgical procedures requires the recipient obtain a documented medical second opinion. Coverage is provided for a documented third opinion, at the recipient's choice, when the second opinion fails to confirm the surgery recommendation of the first opinion.

Bone marrow, heart, kidney, liver and certain restricted multiple organ transplants and related transplantation services are covered when prior authorized. Cornea transplants are covered without a requirement of prior authorization.

PHYSICIAN ATTESTATION POLICY FOR HOSPITALS

Missouri Medicaid's requirements are the same as Medicare Program requirements for physician attestation statements.

2.a. Outpatient Hospital Services

Coverage of services related to the performance of certain specified elective surgical procedures requires the recipient obtain a documented medical second opinion. Coverage is provided for a documented third opinion, at the recipient's choice, when the second opinion fails to confirm the surgery recommendation of the first opinion.

Payment is made to a hospital for physician's services only if the physician is hospital based and has a signed Medicaid participation agreement.

.b. Rural Health Clinic Services

Payment will be made for services provided in a rural health clinic only when that clinic has been certified for participation in the Title XVIII Medicare Program by the Bureau of Hospital Licensing and Certification of the Missouri Department of Health or by comparable agencies in other states.

2.c. Federally Qualified Health Center (FQHC) Services

(1) Provider Participation. To be eligible for participation in the Missouri FQHC program, a provider must submit proof satisfactory to the Division of Medical Services that it meets the following conditions:

(A) The health center receives a grant under section 329, 330 or 340 of the Public Health Services Act or the Secretary of Health and Human Services (HHS) has determined the health center qualifies by meeting other requirements. If a FQHC identified in the grant has multiple sites, the

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FQHC must obtain written confirmation from Public Health Services to the division which identifies the sites included in the grant;

(B) If the provider fails to meet the qualifications in (1)(A) at any time, the provider will be terminated from participation as an FQHC retroactive to the date the qualification was not satisfied. However, if the provider would have otherwise qualified as a provider of clinic services under the Missouri Medicaid program, the provider may request that the services rendered during the period of nonqualification as a FQHC be subject to the payment schedules and conditions of the clinic services program applicable to the period, and must apply for provider enrollment as a clinic provider.

(2) Covered Services. Covered FQHC services include core services defined generally in section 1861(aa)(1)(A)-(C) of the Social Security Act and any other ambulatory services provided for under the Missouri State Plan which are furnished by the FQHC. FQHC services are subject to benefit limitations as described in the Missouri State Medicaid Plan.

(3) General Regulations. This rule shall not encompass all of the general regulations of the Medicaid Program. The regulations, however, shall be in effect for Federally Qualified Health Center Services. Specific descriptions of benefit limitations are found within the Missouri State Medicaid Plan.

3. Laboratory and X-Ray Services

Independent laboratories must meet Medicare certification requirements in order to participate in the Medicaid Program. Reimbursement is provided for all such procedures as may be certified by specialty and subspecialty as performable at that laboratory location with required equipment and facilities. Laboratory or X-ray services referred by a physician must be billed by the laboratory or X-ray service as the performing provider.

4.a. Skilled Nursing Facility Services

No payment for services will be made if the requirement for preadmission screening has not been made prior to admission and a determination made that nursing home placement is appropriate.

Skilled nursing facility services are available to those recipients age 21 or older who have been certified by State Medical Consultant as requiring a skilled nursing level of care. Duration of service is conditional upon periodic, subsequent recertification.

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b. Early and Periodic Screening, Diagnosis, and Treatment Services

Early and periodic screening and diagnostic and treatment services are provided for individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures are provided to correct or ameliorate defects and conditions discovered thereby. Such services shall be provided in accordance with the provisions of 42 U.S.C. Section 1396d and federal regulations promulgated thereunder;

Medically necessary services identified as a result of an EPSDT screening are covered for Medicaid eligible recipients under the age of 21.

Lead screens are provided in accordance with CDC and HCFA guidelines as a component of the EPSDT (HCY) screen. All medically necessary lead treatment services permitted under Medicaid Regulations are covered under respective program areas, i.e., laboratory tests, physician, hospital, pharmacy, environmental assessments, case management, etc.

Specific providers enrolled under the Early Periodic Screening, Diagnosis and Treatment services program include:

Speech Therapists;
Physical Therapists;
Occupational Therapists;
Private Duty Nursing Providers;
Psychologists;
Social Workers;
Professional Counselors;
Environmental Assessment Providers;
Screening providers; and
Case Management providers

Program Descriptions

DURABLE MEDICAL EQUIPMENT (DME) PROGRAM:

A medically necessary item or service that is normally non-covered by Medicaid that is identified as a result of a physician or other health care professional through an EPSDT screening service may be covered for persons under the age of 21 years. Prior authorization is required for specific items such as diapers, corrective shoes, event recorders, positioning equipment, medical/surgical supplies and CPAP devices. Some items that do not require prior authorization but do require a medical necessity form are; jolst-skin burn garments, enteral nutrition, diabetic monitors and supplies, and augmentative devices.

HEARING AID PROGRAM:

A medically necessary item or service that is normally non-covered by Medicaid that is identified as a result of a physician, hearing aid dealer/fitter or audiologist or other health care professional through an EPSDT screening service may be covered for persons under 21 years of age on a prior authorized basis. Examples of items approved under the HCY Hearing Aid Program are diagnostic hearing testing, aural habilitation and FM systems.

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b. Early and Periodic Screening, Diagnosis, and Treatment Services (cont.)

OPTICAL PROGRAM:

A medically necessary item or service that is normally non-covered by Medicaid that is identified as a result of a physician or optometrist through an EPSDT screening service may be covered for persons under the age of 21 years on a prior authorization basis. Items or services that have been prior approved under the HCY Optical Program are such items as replacement eyeglasses within two years and medically necessary contact lenses.

AMBULANCE PROGRAM:

Medically necessary ambulance services for recipients under the age of 21 years are covered as an EPSDT service.

HOSPITAL PROGRAM:

- Outpatient Hospital - Medically necessary occupational therapy, speech/language therapy services, and other services provided in an outpatient hospital facility that are beyond state plan covered services are covered through the EPSDT option. Prior authorization restrictions for the purpose of determining medical necessity may apply to some services.

- Inpatient Hospital - Medically necessary inpatient days beyond the Medicaid allowed number of days are covered through the EPSDT option if prior authorized.

HOME HEALTH:

Intermittent skilled nurse visits, physical therapy, occupational therapy, and speech therapy, and disposable medical supplies are available to children in their homes when there is an established medical need for such services, and the services are not available in another setting or the needs of the child may be more appropriately met in the home. Services are delivered in accordance with a plan of care approved by a physician, and are provided by Medicaid enrolled and Medicare-certified home health agencies.

PRIVATE DUTY NURSING:

The provision of individual and continuous care (in contrast to part-time or intermittent care) by registered or licensed nurses in shifts of 4 to 24 hours per day is covered for children with complicated medical needs, whose care can be safely provided in the home setting. Services are delivered in accordance with a plan of care approved by a physician. Services are provided by qualified agencies enrolling as Medicaid providers of private duty nursing for children.

PERSONAL CARE:

Personal care services, which are assistance with activities of daily living, are covered for children with disabilities who are unable to perform age appropriate functions such as personal hygiene, ambulation, toileting and eating. Services are provided by Medicaid enrolled personal care agencies, and follow a plan of care approved by a physician. Personal care services are distinguished from other home care services such as home health or private duty nursing in that children with chronic and stable conditions may be eligible for personal care, whereas children who are medically fragile and/or require active treatment where skilled nursing or skilled rehabilitative intervention is required will be eligible for services under the home health or private duty programs.

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b. Early and Periodic Screening, Diagnosis, and Treatment Services (cont.)

DENTAL PROGRAM:

Medically necessary dental and orthodontic services beyond state plan covered services are covered for persons under the age of 21 years through the EPSDT option. Orthodontic services require prior authorization to determine medical necessity. Some dental services which are not currently covered under the state plan may require prior authorization to determine medical necessity.

PHYSICIAN PROGRAM:

Physician services which are medically necessary but are not covered in the state plan may be provided for individuals under the age of 21 years through the EPSDT option.

LEAD ENVIRONMENTAL ASSESSMENT:

EPSDT Rehabilitative Option

Lead Environmental Assessment

In accordance with the CDC and Missouri Department of Health guidelines, an environmental assessment will be covered for individuals under the age of 21 who receive lead screens through the EPSDT program and who have blood lead levels of 15 ug/dL or greater. The assessment will be conducted on the child's principle residence. The purpose of the environmental assessment will be to determine the source(s) of hazardous lead exposure in the residential environment.

Medicaid enrolled providers will be reimbursed. Only those providers who are certified by the Missouri Department of Health as meeting the basic education, training and qualifications for lead environmental inspection will be enrolled as Medicaid providers.

The initial visit to the site will include an assessment of the environment, establishing an environmental corrective action plan, educating the parent/guardian on ways to eliminate exposure, and referral to case management services. Follow-up site visits will be covered as medically necessary.

CASE MANAGEMENT:

Medically necessary case management services under Section 1905(a) of the Social Security Act are covered for persons under the age of 21 years through the EPSDT option. Case management includes assessment of need, development of a care plan, and implementing the care plan. Most EPSDT (HCY) case management services require prior authorization except (1) Children with blood lead levels in excess of 15 ug/dL, (2) Services provided by FQHC case management providers.